(v) Not include discriminatory benefit designs that contravene the nondiscrimination standards defined in §156.125.

(c) The State must provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan that includes posting a notice on its opportunity for public comment with associated information on a relevant State website.

(d) A State must notify HHS of the selection of a new EHB-benchmark plan by a date to be determined by HHS for each applicable plan year.

(1) If the State does not make a selection by the annual selection date, or its benchmark plan selection does not meet the requirements of this section and section 1302 of the PPACA, the State's EHB-benchmark plan for the applicable plan year will be that State's EHB-benchmark plan applicable for the prior year.

(2) [Reserved]

(e) A State changing its EHB-benchmark plan under this section must submit documents in a format and manner specified by HHS by a date determined by HHS. These must include:

(1) A document confirming that the State's EHB-benchmark plan definition complies with the requirements under paragraphs (a), (b) and (c) of this section, including information on which selection option under paragraph (a) of this section the State is using, and whether the State is using another State's EHB-benchmark plan;

(2) An actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, that affirms:

(i) That the State's EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan, as defined at (b)(2)(i) of this section; and

(ii) That the State's EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in paragraphs (b)(2)(ii)(A) and (B) of this section.

(3) The State's EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the State is selecting its EHB-benchmark plan using the option in paragraph (a)(3) of this section, a formulary drug list in a format and manner specified by HHS; and

(4) Other documentation specified by HHS, which is necessary to operationalize the State's EHB-benchmark plan.

[83 FR 17068, Apr. 17, 2018]

§156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of §156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under §156.110(a)(5) of this subpart, comply with the requirements of §146.136 of this subchapter.

(4) Include preventive health services described in §147.130 of this subchapter.

(5) With respect to habilitative services and devices—

(i) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings;

(ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such

limits imposed on coverage of rehabilitative services and devices; and

(iii) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices.

(6) For plan years beginning on or after January 1, 2016, for pediatric services that are required under §156.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age.

(b) An issuer of a plan offering EHB may substitute benefits for those provided in the EHB-benchmark plan under the following conditions—

(1) The issuer substitutes a benefit that:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(4) of this section; and

(ii) Is not a prescription drug benefit.

(2) An issuer may substitute a benefit under this paragraph:

(i) Within the same EHB category, unless prohibited by applicable State requirements; and

(ii) For plan years beginning on or after January 1, 2020, between EHB categories, if the State in which the plan will be offered has notified HHS that substitution between EHB categories is permitted in the State.

(3) The plan that includes substituted benefits must:

(i) Continue to comply with the requirements of paragraph (a) of this section, including by providing benefits that are substantially equal to the EHB-benchmark plan;

(ii) Provide an appropriate balance among the EHB categories such that benefits are not unduly weighted toward any category; and

(iii) Provide benefits for diverse segments of the population.

(4) The issuer submits to the State evidence of actuarial equivalence that is:

(i) Certified by a member of the American Academy of Actuaries;

(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(iii) Based on a standardized plan population; and

(iv) Determined without taking cost-sharing into account.

(c) A health plan does not fail to provide EHB solely because it does not offer the services described in §156.280(d) of this subchapter.

(d) An issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

[78 FR 12866, Feb. 25, 2013, as amended at 80 FR 10871, Feb. 27, 2015; 81 FR 12349, Mar. 8, 2016; 83 FR 17069, Apr. 17, 2018]

§156.120 Collection of data to define essential health benefits.

(a) *Definitions.* The following definitions apply to this section, unless the context indicates otherwise:

Health benefits means benefits for medical care, as defined at §144.103 of this subchapter, which may be delivered through the purchase of insurance or otherwise.

Health plan has the meaning given to the term ''Portal Plan'' in §159.110 of this subchapter.

State has the meaning given to that term in §155.20 of this subchapter.

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitations include only quantitative treatment limitations. A permanent exclusion of all benefits for a particular condition or disorder is not a treatment limitation.

(b) *Reporting requirement.* A State that selects a base-benchmark plan or an issuer that offers a default base-benchmark plan in accordance with §156.100 must submit to HHS the following information in a form and manner, and by a date, determined by HHS:

(1) Administrative data necessary to identify the health plan;

(2) Data and descriptive information for each plan on the following items:

(i) All health benefits in the plan;

(ii) Treatment limitations;

(iii) Drug coverage; and

(iv) Exclusions.

[80 FR 10871, Feb. 27, 2015]